PRINTED: 03/19/2012 FORM APPROVED OMB NO. 0938-0391

OF CORRECTION	IDENTIFICATION NUMBER: 15G593	A. BUILDING B. WING	00		MPLETED 03/2012	
	R	STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HORART IN 46342				
_	STATEMENT OF DEFICIENCIES	ID	·	CORRECTION	(X5)	
(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION	N SHOULD BE	COMPLETION	
REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
This visit was for t licensure survey.	he full recertification and state	W0000				
certification revisit	(PCR) to the investigation of					
	-					
1						
Provider number:	15G593					
III/QMRP-Team L	eader					
state findings in ac Quality Review co.	cordance with 460 IAC 9. mpleted 2/29/12 by Ruth					
	This visit was for t licensure survey. This visit was in co certification revisit complaint #IN0009 This visit was in co PCR to the investig #IN0009154. Dates of Survey: February 2 and 3, 2 Facility number: OProvider number: AIM number: 100 Surveyors: Christine Colon, M. III/QMRP-Team L. Tim Shebel, Medical The following feders state findings in ac Quality Review co.	PROVIDER OR SUPPLIER DIANA INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for the full recertification and state licensure survey. This visit was in conjunction with the post certification revisit (PCR) to the investigation of complaint #IN00098364. This visit was in conjunction with the PCR to the PCR to the investigation of complaint #IN0009154. Dates of Survey: January 23, 24, 26, 27 and February 2 and 3, 2012 Facility number: 001107 Provider number: 15G593 AIM number: 100245570	PROVIDER OR SUPPLIER DIANA INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for the full recertification and state licensure survey. This visit was in conjunction with the post certification revisit (PCR) to the investigation of complaint #IN00098364. This visit was in conjunction with the PCR to the PCR to the investigation of complaint #IN0009154. Dates of Survey: January 23, 24, 26, 27 and February 2 and 3, 2012 Facility number: 001107 Provider number: 15G593 AIM number: 100245570 Surveyors: Christine Colon, Medical Surveyor III/QMRP-Team Leader Tim Shebel, Medical Surveyor III/QMRP, MSW The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/29/12 by Ruth	PROVIDER OR SUPPLIER DIANA INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for the full recertification and state licensure survey. This visit was in conjunction with the post certification revisit (PCR) to the investigation of complaint #IN00098364. This visit was in conjunction with the PCR to the PCR to the investigation of complaint #IN0009154. Dates of Survey: January 23, 24, 26, 27 and February 2 and 3, 2012 Facility number: 001107 Provider number: 15G593 AIM number: 100245570 Surveyors: Christine Colon, Medical Surveyor III/QMRP, MSW The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/29/12 by Ruth	PROVIDER OR SUPPLIER DIANA INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for the full recertification and state licensure survey. This visit was in conjunction with the post certification revisit (PCR) to the investigation of complaint #IN00098364. This visit was in conjunction with the PCR to the PCR to the investigation of complaint #IN0009154. Dates of Survey: January 23, 24, 26, 27 and February 2 and 3, 2012 Facility number: 001107 Provider number: 15G593 AIM number: 100245570 Surveyors: Christine Colon, Medical Surveyor III/QMRP-Team Leader Tim Shebel, Medical Surveyor III/QMRP, MSW The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/29/12 by Ruth	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	LIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	A. BUILDING 00			COMPLETED	
		15G593	B. WIN			02/03/	2012	
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				2ND PL E			
REM-IND	DIANA INC				RT, IN 46342			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
W0104		DDY ody must exercise general nd operating direction over						
	_	ation and interview, the	W0	104	W104: The governing body v	vill	03/12/2012	
			'''	- • •	exercise general policy, budge		55, 12, 2012	
		failed for 7 of 7 clients			and operating direction over th			
	, , ,	3, #4, #5, #6 and #7)			facility. The facility will			
		p home, to exercise			ensure damages to the home			
		g direction in a manner to			environment are repaired and items replaced as necessary.	or		
	ensure routine ma	aintenance was			The Home manager will			
	completed.				ensure the repair of maintenar	nce		
	Findings include	:			issues in the home including replacing toilet paper holders in two bathrooms, repair to the hole	n ole		
	_	vation was conducted on 5 A.M. until 8:15 A.M			in the wall of client #5 bedroon repair or replace of dresser an desk and carpets of the home	d		
		e living room of clients 5, #6 and #7's home, the			cleaned. In the future, theHom Manager will monitor the home	е		
		hallway carpet was			daily fmaking a list of needed			
	_	black stains throughout.			repairs and contact a repairma as necessary to ensure the ho			
		e bathroom located off			is in good repair. The Program			
		ot have a toilet paper			Director will observe in the hor			
		room located off the			weekly for a month and on a			
		to the clients' bedrooms			monthly basis thereafter to			
		ilet paper holder. At			ensure the home is in good repair. Person responsible: Arc	<u>-</u> a		
		#5's bedroom was			Director	Ju		
	•							
		a 4 inch by 4 inch hole o the bedroom window.						
		s room had one of four						
	_	The desk in his room						
		have a door hanging and						
	a missing drawer	front.						
	An interview wit	h the Group Home						

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Event ID: C8BH11

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G593	A. BUII B. WIN	LDING	00	COMPL 02/03/	ETED
	PROVIDER OR SUPPLIER		b. WIN	STREET A 3142 62	DDRESS, CITY, STATE, ZIP CODE		
REM-IND	DIANA INC			HOBAR	T, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	1/23/12 at 3:13 P indicated the toile to be replaced. To carpeting needed not been cleaned also indicated the repairs/replacing needed to be fixed. An interview with Retardation Professional Completed on 1/2 QMRP indicated completed. The efforms for this ground documentation with the contraction of the contraction	et paper holders needed The GHM indicated the to be cleaned and had since November. He et dresser and desk needed and the hole in the wall					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		15G593	B. WIN			02/03/2	2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				2ND PL E		
DEM IND	DIANA INC				2ND PL E RT, IN 46342		
KEIVI-IINL	JIANA INC			ПОВАР	(1, IN 46542		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
PREFIX	(EACH DEFICIENT REGULATORY OR 483.420(b)(1)(i) CLIENT FINANC The facility must system that assus accounting of clie entrusted to the facility failed to accounting system at the group hom whom the facility funds accounts. Findings include A review of the facility funds accounts. Findings include A review of the facility funds accounts. Client #5's person ledger dated 1/22 have a balance of Professional (DS currency in client and counted a balance of a second counted a balance of accounted a balance of accounted a balance of a second counted a second counter	CES establish and maintain a ares a full and complete ents' personal funds facility on behalf of clients. review and interview, the maintain an accurate en for 2 of 7 clients living the (clients #5 and #7), for an anaged their personal end indicated the ents's review of clients #5 and end indicated the ents's personal end indicated the ents's personal end indicated the ents's petty cash pouch established pouch established personal ents and end indicated the ents's petty cash pouch	W0	PREFIX TAG	W140: The facility currently ha system in place that assures a and complete accounting of clients' personal funds entruste to the facility on behalf of the clients. The clients' personal funds are kept maintained in the office of the group home and sis trained on the procedure for finances upon hire. The client petty cash funds have been balanced and money accounte for. The client missing 11 cent has been reimbursed. The Homanager will be retrained to follow the financial policy to ensure all client accounts remains a lanced at all times. In the future, the Home Manager will monitor the client funds at least weekly and the Program Direct will monitor the finances at least monthly to ensure they are maintained according to policy Responsible Party: Program Director	s a full ed he taff	COMPLETION
	have a balance of Professional (DS	2/12 indicated she should f \$.94. Direct Support dP) #1 reviewed the t #7's petty cash pouch lance of \$.83.					

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	OF CORRECTION IDENTIFICATION NUMBER: 15G593	A. BUILDING B. WING	00	COMPLETED 02/03/2012
	PROVIDER OR SUPPLIER DIANA INC	3142 621	DDRESS, CITY, STATE, ZIP CODE ND PL E T, IN 46342	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/24/12 at 1:30 P.M The QMRP indicated each client's ledger entry balance and the currency amount should always match. 9-3-2(a)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G593	B. WING		02/03/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		2ND PL E	
REM-IND	DIANA INC			RT, IN 46342	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	BROWNERS N. AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
W0149	483.420(d)(1) STAFF TREATM The facility must written policies a mistreatment, not assed on record 1 of 7 clients rese (client #7), the fi implement its absuring the clie vehicle unattend. Findings included A review of the conducted on 1/2 Review of the far Developmental 1 (BDDS) report the following: Incident report of Director pulled an noticed the indivision without staff presonducted on 1/2 Review of client plan (ISP) dated required 24 hours.	MENT OF CLIENTS t develop and implement and procedures that prohibit eglect or abuse of the client. Treview and interview, for siding at the group home facility neglected to puse/neglect policy by nt was not left in a ded. E: facility's records was 26/12 at 12:45 P.M ncility's Bureau of Disabilities Services dated 1/23/12 indicated dated 1/23/12 indicated dated 1/23/12: "The Area up at the gas station and widuals was (sic) in the car esent." This incident day program hours. nt #7's record was 24/12 at 10:30 A.M t #7's Individual Support 16/10/11 indicated he	W0149	W149: The facility currently havitten policy and procedure of mistreatment, neglect or abuse a client and the reporting there of. All new employees are trained the policy and the procedur clients to protect the clients and report any client injury to the proper authorities within and outside the agency. The facility has retrained the diprogram remaining staff on the supervision level for clients living in the group home to ensure safety. The staff involved in the reported incident has been terminated. In the future the Program Dire will monitor the staff ensure protective measures implementare in place and remain active. The facility will continue to traitemployees to follow company policy to ensure safety for all the individuals. Person responsible: Program Director	as a ne of e ined re ad lay e ing le ctor ated . n all
1		,,			1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION 00	COMI	(X3) DATE SURVEY COMPLETED	
		15G593	B. WING			3/2012
	PROVIDER OR SUPPLIE	R	3142	T ADDRESS, CITY, STATE, ZIP 62ND PL E ART, IN 46342	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Review of the fall "We are paid to serve are kept so people we serve a group considered endar Failing to provinceded for a permental health to well being is im Neglect include responsibly to penough food, cleare, supervision physical and soon An interview we program Supervon 2/3/12 at 2:0 indicated the statunattended/unsuinto the gas statindicated the face	acility's policy indicated: ensure the individuals we afe at all times. The also have the right to be eglect and exploitation. up of individuals ungered adultsNeglect: de good care that is rson's physical and/or the extent that his or her paired or threatened. Is the failure to act rovide proper food, othing, shelter, health or or protection from cial danger." Ith the facility's Day visor (DPS) was conducted O P.M The DPS off left the client in the car upervised while she went ion. The DPS further cility's abuse neglect the followed at all times.				

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G593	A. BUILE B. WING	ING	00	COMPL 02/03/	ETED	
	ROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	

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Facility ID: 001107

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IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G593	A. BUII	LDING	ONSTRUCTION 00	(X3) DATE COMPL 02/03 /	ETED
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		RCEDED BY FULL PREFIX GINFORMATION) PREFIX PREFIX CROSS-REFERENCED TO THE AP DEFICIENCY) ENTS			I	(X5) COMPLETION DATE
Based on record 1 of 1 incident of involving 1 of 7 or group home (clie to provide evider investigation was Findings include A review of the factor of the factor of the factor of the following: Incident report of the factor of the following: Incident report of the following: Incident report of the following: A review of client of the indiviction of the individual of the in	review and interview for falleged neglect, clients residing at the ent #7), the facility failed nee a thorough s conducted. Cacility's records was 26/12 at 12:45 P.M cility's Bureau of Disabilities Services dated 1/23/12 indicated ated 1/23/12: "The Area p at the gas station and iduals was (sic) in the car sent." This incident day program hours. at #7's record was 24/12 at 10:30 A.M #7's Individual Support 6/10/11 indicated he	Wo	154	W154: The facility currently tra all supervisors upon hire on the policy and format of investigation of client incidents, reporting procedures and follow up to concidents requiring investigation. The Area Director will retrate the Home Manager and Proground Director to adhere to guideline immediate investigation and suspension of staff with allege suspect of allegation of client mistreatment, neglect or abust The training will include investigation of such incident investigated thoroughly and reported within 24 hours as mandated In the future, the Program Director will immediately beging investigation upon receiving information on suspected allectient mistreatment, neglect, cabuse. The director will follow guidelines of completion of the investigation within the designated timeframes outlined the policy. The Area Director follow up with Program Director ensure the investigation is meeting criteria of the companyolicy. Person responsible: Area Director follow and the policy. Person responsible: Area Director follow and the policy.	ne tion lient on. ain ram es of ed he. is n an ged or v the e es in will or to	03/12/2012

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	of correction identification number: 15G593	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI 02/03.	ETED
	PROVIDER OR SUPPLIER DIANA INC	3142 62	ADDRESS, CITY, STATE, ZIP 2ND PL E RT, IN 46342	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	on 2/3/12 at 2:00 P.M The DPS indicated the staff left the client in the car unattended/unsupervised while she went into the gas station. The DPS further indicated the investigation was still ongoing and she didn't have written documentation to indicate a thorough investigation had been completed. 9-3-2(a)				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		15G593	B. WIN			02/03/2012	
			b. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				2ND PL E		
REM-IND	DIANA INC				RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W0225	483.440(c)(3)(v) INDIVIDUAL PROTHER COMPREHENS must include, as Based on record facility failed to a needs of 4 of 4 sa vocational assess and #4). Finding include: Client #1's record fair vocational needs assessed. Client #2's record fair vocational needs assessed. Client #3's record fair vocational needs assessed. Client #4's record fair client's vocational needs assessed.	OGRAM PLAN sive functional assessment applicable, vocational skills. review and interview, the assess the vocational ampled clients requiring sment (clients #1, #2, #3,	WO		W225: The facility currently completes assessments on all clients upon admission and annually prior to the client Individual Support Team meet to determine the needs of the client and to establish programming goals for those needs. Vocational skills assessments have been completed on Client 1, 2, 3, a 4. In the future, the Home Manager will ensure that each client is re-assessed vocationa annually and when client beha or day program situation warrathe need. The Program Direct will monitor the vocational progress by reviewing monthly data from day program to ensuthe client is in a situation to me his potential. Responsible Staf Area Director	ing ally vior ants tor ure eet	DATE 03/12/2012

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	of Correction identification number: 15G593	(X2) MULTIPLE CC A. BUILDING B. WING	00				
	PROVIDER OR SUPPLIER DIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	client's vocational needs and abilities had been assessed.						
	Program Director #1 was interviewed on 1/24/12 at 1:09 P.M Program Director #1 indicated client #1, #2, #3, and #4's vocational needs and abilities had not been assessed. 9-3-4(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		15G593	B. WIN			02/03/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ND PL E		
REM-IND	DIANA INC				RT, IN 46342		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0248	be made availab including staff of with the client, at the client is a min Based on record interview, the facupdated Individu for 1 of 2 clients day program (cliestaff who worked Findings include Client #5's record 1/24/12 at 12:15 indicated a most An outside day producted on 1/2 until 1:30 P.M period client #5 valking to himsel record was conducted on 1/2 talking to himsel record was conducted was conducted the most current ISP	dient's individual plan must le to all relevant staff, other agencies who work and to the client, parents (if nor) or legal guardian. review, observation and cality failed to have an lal Support Plan (ISP) observed at the outside ent #5), available for all diat the day program. diat was reviewed on P.M Client #5's record current ISP dated 2/1/11. Program observation was 27/12 from 12:00 P.M. During the observation walked around the room of A review of client #5's facted at 12:15 P.M A less record indicated a dated 2/1/10. The Day Program of the parents of the p	W0	248	W248: The facility provides a copy of each client's individual plan to all other providers, the client and to the parents or leg guardian. All clients' Individual Progra Plans have been provided to the day program to ensure cohesi in client care is maintained. The Program Director has been trained to ensure that the day program receives each cliupdated program plans in the future. Responsible Party: Program Director	gal am he on	03/12/2012

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G593		ATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 02/03/2012		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342				
(X4) ID PREFIX TAG	SUMMARY STATEMENT (EACH DEFICIENCY MUST E REGULATORY OR LSC IDENT	E PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	An interview with the Qu Retardation Professional conducted on 2/3/12 at 2: QMRP indicated the day should have an updated IS 9-3-4(a)	(QMRP) was 20 P.M The program staff					

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Event ID: C8BH11

Facility ID: 001107

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G593			LDING	ONSTRUCTION 00	(X3) DATE : COMPL 02/03 /	ETED	
	PROVIDER OR SUPPLIER		p. why	STREET A	ADDRESS, CITY, STATE, ZIP CODE 2ND PL E RT, IN 46342	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
W0259	At least annually functional assess reviewed by the relevancy and up. Based on record facility failed to a functional assess least annually for living in the grout #3, and #4). Findings include Client #1's record 1/24/12 at 9:59 A indicated client # functional assess 12/27/10. Client #2's record 1/24/12 at 9:02 A indicated client # functional assess 12/27/10. Client #3's record 1/24/12 at 10:22 indicated client # functional assess 12/28/10.	Altorian Schange and the comprehensive sment of each client must be interdisciplinary team for odated as needed. The review and interview, the assure a comprehensive ment was reviewed at at 4 of 4 sampled clients up home (clients #1, #2, and the sampled clients are home). The review the sampled on the s	W0	259	W 259: The facility currently completes assessments and completes a comprehensive functional assessment on each client annually that is reviewed the team for relevancy and updated as needed. The CF for clients 1,2, 3, and 4 have to completed and goals updated the Program Director. In addit those documents will be reviewed by the team and filed in the client's book in the home. The Program Director has been re-trained to adhere to the client annual review schedule and provide up to date inforamtion including the client CFA in the home. In the future, the Area Director will monitor the schedule and provide up to date inforamtion including the client CFA in the home. In the future, the Area Director will monitor the schedule and provide up to date inforamtion including the client CFA in the home. In the future, the Area Director will monitor the schedule and provide up to date information including the client CFA in the home. In the future, the Area Director will monitor the schedule and provide up to date information. In the future, the Area Director will monitor the schedule and provide up to date information including the client CFA in the home. In the future, the Area Director will monitor the schedule and provide up to date information. In the future, the Area Director will monitor the schedule and provide up to date information. In the future, the Area Director will monitor the schedule and provide up to date information.	d by FA Deen by tion wed ent dule the he	03/12/2012

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	of Correction identification number: 15G593	(X2) MULTIPLE CC A. BUILDING B. WING	00	02/03	LETED 5/2012
	PROVIDER OR SUPPLIER	3142 62 HOBAF			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	1/24/12 at 12:40 P.M The review indicated client #4's last comprehensive functional assessment was completed on 12/27/10.				
	Program Director #1 was interviewed on 1/24/12 at 1:07 P.M Program Director #1 indicated the facility did not have documentation of current comprehensive functional analysis being conducted for clients #1, #2, #3, and #4. 9-3-4(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G593	B. WING		- 02/03/2012	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER		2ND PL E		
REM-IND	DIANA INC			RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
TAG W0323	483.460(a)(3)(i PHYSICIAN SE The facility must physical examin minimum include hearing. Based on record facility failed for (client #1) to hat exam as recommunity from the exam as recommunity from the exam as recommunity in the exam as	ERVICES st provide or obtain annual nations of each client that at a des an evaluation of vision and dreview and interview, the or 1 of 4 sampled clients ave a follow up vision mended by the physician. e: ent #1's record was /24/12 at 9:25 A.M rd indicated a most current on dated 5/11/09 which low up in one year." rd did not contain ad a follow up in one year. Nurse (RN) was 1/24/12 at 11:56 A.M ed client #1 did not return	W0323	W 323: The facility currently completes assessments for e client annually to ensure upda cognitive, social and medical information is obtained to provided quality care to the client. The Home Manager has scheduled the vision exam for client #1 to assess the client vision. The Home manager, Program Director and facility nurse have been re-trained to accurately ensure all clients receive the follow up medical as required. In the future, the facility nu will monitor the schedule of clappointments and ensure the clients receive medical assessments in a timely manu within annual timeframe. Responsible party: Facility N	ach ated 03/12/2012 care urse ient ner	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLE			ETED	
		15G593	B. WIN			02/03/	2012
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
REM-IND	DIANA INC				2ND PL E RT, IN 46342		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX				COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0436	repair, and teach informed choices eyeglasses, hea communications	furnish, maintain in good n clients to use and to make s about the use of dentures, ring and other aids, braces, and other d by the interdisciplinary team					
	interview, for 1 of wore eyeglasses		W0-	436	W436 The facility will furnish, maintain in good repair, and teach clients to use and to mal informed choices about the us dentures, eyeglasses, hearing and other communications aid braces and other devices identified by the interdisciplina team as needed by the client.	e of s, ry	03/12/2012
	the group home of A.M. until 8:15 A observation period her prescribed ey not prompted by eyeglasses. An outside day p	evation was conducted at on 1/23/12 from 5:45 A.M During the entire od client #1 did not wear reglasses. Client #1 was staff to wear her program observation was 23/12 from 11:00 A.M.			The home manager will ensure that Client 1's glasses are available or purchased by the facility. The facility will implem a goal for client 1 to be encouraged to wear her glasse as needed. The direct support professionals will be trained to implement the goal for client to wear the eyeglasses. In the future, the Program Director will ensure client device.	ent es t	
	until 11:30 A.M. observed during period not wearing was not prompte prescribed eyegla. An evening obse	. Client #1 was the entire observation ng eye glasses. Client #1 d by staff to wear her			are available and clients are encouraged to use the devices. The Home Manager will compl a active treatment observation once weekly for 4 weeks to ensure the staff are completing the goal as written and to ensure the clients needs are being metals. Person Responsible: Area	ete J ire	

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	of Correction identification number: 15G593	(X2) MULTIPLE CO A. BUILDING B. WING	00	COME	E SURVEY PLETED 3/2012
	PROVIDER OR SUPPLIER DIANA INC	3142 6	address, city, state, zii 2ND PL E RT, IN 46342	P CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
			CROSS-REFERENCED TO TI- DEFICIENCY) Director	HE APPROPRIATE	
	9-3-7(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G593	B. WING		02/03/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R		S2ND PL E	
	DIANA INC			RT, IN 46342	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W0484	The facility mus chairs, eating ut to meet the devicient.	S AND SERVICE t equip areas with tables, rensils, and dishes designed elopmental needs of each vation and interview, the	W0484	W484: The facility provides ea	ach 03/12/2012
	facility failed fo #2, #3, #4, #5, # group home to p dining table.	r 7 of 7 clients (clients #1, 66 and #7) living in the provide condiments at the	W 0+0+	group home fully furnished wit necessary domestic equipmer meet the needs of the clients. The areas of the group home equipped with dining impleme designed to meet the	ht to
	the group home A.M. until 8:15 clients #1, #2, # observed eating consisted of grit english muffins to have no butte substitute, salt, I Group home sta out any condime An interview wi Retardation Pro- conducted on 1/ QMRP indicated	rvation was conducted at on 1/23/12 from 5:45 A.M At 7:45 A.M., 3, #4, #5, #6 and #7 were breakfast. The meal s, scrambled eggs and The table was observed r, jelly or sugar/sugar pepper, ketchup or milk. ff #1 and #2 did not put ents for the clients to use. th the Qualified Mental fessional (QMRP) was 24/12 at 1:30 P.M The d condiments should be for the clients to use at all		developmental needs of the clients. The Home Manager will trathe staff to provide the clients all dining utensils and items needed for meal enjoyment including condiments. In the future, the facility stawill offer the clients all mealtim furnishings and utensils. The Home Manager will complete weekly observations to ensure the staff provide all items necessary to eat their meal where providing choices. Responsible Staff: Area Directions and the staff provide all items necessary to eat their meal where the staff providing choices.	will iff ne ine

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	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 15G593	A. BUILDING B. WING	00	COMI	E SURVEY PLETED 3/2012		
REM-IND	ROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	CORRECTION N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
		15G593	B. WIN	_		02/03	/2012
NAME OF	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 2ND PL E		
REM-INI	DIANA INC				RT, IN 46342		
(X4) ID	SUMMARY S	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0488	in a manner considevelopmental le Based on observatinterview, the face	assure that each client eats sistent with his or her evel. ation, record review, and cility failed to assure 4 of	Wo	488	W488: The facility will ensure each client eats and prepare food in a manner consistent his or her developmental lev	s with el.	03/12/2012
	_	s living in the group			Staff will be retrained on mea		
	home (clients #1				procedure to teach such skill and provide role modeling to		
	participated in fa	mily style dining.			clients. The training will inclu	ıde	
	Findings include	:	family style dining, self dining, client participation in food preparation and mealtime tasks.				
	the group home of A.M. until 8:15 A observation Dire prepared grits, so english muffins. the morning mea sat in the living re Client #2 stayed A.M., DCS #1 w and served each of their plates and be	evation was conducted at on 1/23/12 from 5:45 A.M During the ct Care Staff (DCS) #1 crambled eggs and While DCS #1 prepared Il clients #1, #3 and #4 coom with no activity. in his bedroom. At 7:45 calked around the table client their breakfast onto owls. Clients #1, #2, #3 esist in meal preparation e themselves.			preparation and mealtime tasks. The Home Manager will ensure that all staff are trained and will monitor mealtime activities at least weekly to ensure that individuals are serving themselves and participating in meal preparation according to their developmental level. Person Responsible: Program Director		
	at the group hom observation period P.M. until 5:40 F observation, Direct	•					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE (COMPL		
		15G593	A. BUII B. WIN	LDING		02/03/	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				ND PL E		
REM-IND	DIANA INC			HOBAR	T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		d eggs and placed the					
	_	dishes and placed the					
		ng room table for clients					
	#1, #2, #3, and #	4. While direct care staff					
	#1 prepared the	evening meal, client #1					
	sat at the comput	ter in the small dining					
	· ·	vas in his bedroom, client					
		rision, and client #4					
		t care staff #1. Direct					
	care staff #2 was not observed to prompt						
	or assist clients #1, #2, #3, or #4 in						
	assisting with the evening meal.						
	Client #1's record	ds were reviewed on					
	1/24/12 at 9:59 A	A.M A review of the					
	client's 12/27/10	Comprehensive					
	Functional Asses	ssment indicated the					
		opmentally capable of					
	participating in c	lining and meal tasks.					
	Client #2's recor.	ds were reviewed on					
		A.M A review of the					
	client's 12/27/10						
		ssment indicated the					
		opmentally capable of					
		lining and meal tasks.					
		ds were reviewed on					
		A.M A review of the					
	client's 12/28/10	_					
		ssment indicated the					
		opmentally capable of					
	participating in c	lining and meal tasks.					

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G593	A. BUILDING B. WING			COMPLETED 02/03/2012	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342				
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR Client #4's record	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ds were reviewed on P.M A review of the		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	"E	(X5) COMPLETION DATE
	client's 12/27/10 Functional Asses client was develo						
	1/24/12 at 1:09 P #1 indicated clien were developmen	r #1 was interviewed on P.M Regional Director ents #1, #2, #3, and #4 entally capable of the family dining process.					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
15G593		A. BUILDING			02/03/	2012	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
			3142 62ND PL E				
REM-IND	IANA INC		HOBART, IN 46342				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)						DATE
W9999							
	State Findings		W9999		W 9999: The facility currently		03/12/2012
					completes assessments		00,, -0
					incorporated in the		
		ctive Treatment Services			comprehensive functional assessment on each client		
	(b) The provider	shall obtain day services					
	for each resident	which: (1) meet the			annually that is reviewed by th	at is reviewed by the	
	criteria and certification requirements				team for relevancy and updated		
	established by the division of aging and				as needed. The assessments		
					include vocational/day		
	rehabilitative services for all day service				program skills of the client to)	
	providers; (2) meet the resident's active				determine the appropriation		
	treatment needs set forth in the resident's				day program for the client.	_	
	individual progra	nm plan as determined by			Client #2 has been assesse		
	the interdisciplin	ary team conference with			for vocation skills by the facility		
	preferences for services in the least				day program. The client is in t process of a trial period in the		
	restrictive enviro				program to determine if the	uay	
	restrictive criviro	illinent.			program meets the needs of the	ne	
					client at this time. The Program		
	This state rule wa	as not met as evidenced	nced		Director will		
	by:				ensure documentation of the		
					client day program activities is		
	Based on observation, record review, and				completed and reviewed.		
	interview, the facility failed to meet the				In the future, the Area		
		-			Director will monitor the sched		
		needs pertaining to day			of day program activies weekly	y to	
		ming for 1 of 4 sampled			ensure the Program		
	clients (client #2)).			Director ensures the client		
					is active in a day program that suits the client needs. The		
	Findings include	:			Program Director will ensure if	· a	
	S				day program is not meeting the		
	Client #2 were of	bserved on 1/23/12 from			needs of the client, a team	-	
					meeting will be held to		
		:54 P.M. During the			determine what would be best	for	
	observation client #1 napped in his room				the client needs at the given time.		
	and watched tele	vision. No alternative			Responsible Person: Area		
	day services were	e observed to be			Director		
	provided.						
	P-0 11404.		1				

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	OF CORRECTION IDENTIFICATION NUMBER: 15G593	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/03/2012		
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE COMPLETION		
	Client #2's records were reviewed on 1/24/12 at 9:02 A.M A review of the client's day services activities for the week of 1/16/12 through 1/20/12 indicated client #2 participated in the following day service activities: "1/16/12, 7am-3pm - played board game. 1/17/12, 7am-3pm - community activity, ate lunch, watched TV. 1/18/12, 7am-3pm - went out into community, ate lunch, watched TV. 1/19/12, 7am-3pm - showered, ate lunch, went to pet store, started laundry, watched TV. 1/20/12, 7am-3pm - went to [name to stores], & watched TV." Regional Director #1 was interviewed on 1/24/12 at 1:09 P.M Regional Director #1 indicated the facility is working to acclimate client #2 to the facility's community day services program. Regional Director #1 further stated client #2 was not participating in the facility's day services program "at this time." When asked if client #2's present day services activities met the criteria and certification requirements established by the Division of Aging and Rehabilitative Services for all day service providers, Regional Director stated she wasn't sure, but "it (facility's day programming services) probably didn't." 9-3-4(a)					

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G593	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMF 02/03	E SURVEY LETED 3/2012	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	CORRECTION ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	

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